AVIVA LTD
DENTAL CLAIM FORM

(Patient is required to pay the dentist and attached receipt to seek reimbursement from Aviva Ltd)

SECTION I – TO BE COMPLETED BY THE EMPLOYEE

Name of Company		Policy/Card Number	
Commencement of employment (dd/mm/yyyy)	Market unit/Dept	Daytime Contact No. (Mobile/Pager/Tel) *	
Name of Patient	NRIC/BC/FIN No. of Patient	Sex *M/F **	Date of Birth (dd/mm/yyyy)
Name of Employee (If the patient is not the employee)	NRIC/FIN No. of Employee	Sex *M/F **	Date of Birth (dd/mm/yyyy)

Relationship	*All reimbursements will be credited into your payroll's bank account, please furnish your bank account number only if there are recent changes to your bank account.*		
*Wife/Husband/Son/Daughter **	Name of Bank	Branch Name / Branch Code	Account Number
EMPLOYEE'S SIGNATURE	Office email address (If available)		

SECTION II – TO BE COMPLETED BY THE DENTIST

Date of Treatment	*AVIVA Office Code*	*No. of Tooth Treated*	*Amount Incurred*	*Others (please indicate tooth number)*	*Amount Incurred*
TYPE OF TREATMENT					
1. Consultation / Examination	A01				
2. Scaling and Polishing	C01				
3. X-rays					
i) Periapical	B01	______	_______		
ii) Bite Wing	B02	______	_______		
iii) Occlusal Film	B03	______	_______		
iv) Orthopantograph	B04	______	_______		
4 Amalgam Restoration					
i) 1 Surface	D01	______	_______		
ii) 2 Surfaces	D02	______	_______		
iii) 3 Surfaces	D03	______	_______		
5. Tooth Colored Restoration					
i) 1 Surface	E01	______	_______		
ii) 2 Surfaces	E02	______	_______		
iii) 3 Surfaces	E03	______	_______		
6. Extraction of Tooth (inclusive of LA)					
i) Anterior Tooth	F01	______	_______		
ii) Posterior Tooth	F02	______	_______		
7. Oral Surgery (inclusive of LA)					
i) Incision & Drainage	G01	______	_______		
ii) Excision of Hyper Plastic Tissue, Cyst	G02	______	_______		
iii) Surgical Root Removal (per root)	G03	______	_______		
iv) Surgical Removal of Wisdom Tooth (Soft Tissue)	G04	______	_______		
v) Surgical Removal of Wisdom Tooth (Simple Bony Impaction)	G05	______	_______		
8. Periodontal Treatment Root Planning					
i) Per Tooth	H01	______	_______		
ii) Per Quadrant	H02	______	_______		
9. Pulp/Root Canal Treatment					
i) Pulp Capping	I01	______	_______		
ii) Root Canal - 1 Canal	I02	______	_______		
2 Canals	I03	______	_______		
10. Miscellaneous Treatment					
i) Analgesics (Oral Only)	J01		_______		
ii) Antibiotics (Oral Only)	J02		_______		
iii) Administration of local Anesthesia	J03		_______		
T O T A L					

Name of Dentist	
DENTIST'S SIGNATURE & CLINIC'S STAMP	DATE

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* Delete where applicable

Note :-

1. Section I is to be completed by Employee.

2. Section II is to be completed by DENTIST.

3. Employee to pay the dentist after treatment and attached your receipt together with the completed claim form and submit to:-

Aviva Ltd
Group Life & Health Claims
4 Shenton Way
#01-01 SGX Centre 2
Singapore 068807

4. To expedite reimbursement, please provide your bank account for direct credit into your account. A payment advice will be sent upon credit to your bank account.